

PHYSICAL MEDICINE

GENERAL INFORMATION

Physical and occupational therapy services must be ordered by the worker's:

- Attending doctor
- Nurse practitioner or
- By the physician assistant for the attending doctor.

Who May Bill For Physical Medicine Services

Board Certified Physical Medicine and Rehabilitation (Physiatry) Physicians

Medical or osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation may provide physical medicine services.

- They use CPT[®] codes 97001 through 97799 and 95831 through 95852 to bill for their services.
- CPT[®] code 64550 may also be used but is payable only once per claim (see [WAC 296-21-290](#)).

Licensed Physical Therapists

Physical therapy services must be provided by a licensed physical therapist or a physical therapist assistant serving under the supervision of a licensed physical therapist (see [WAC 296-23-220](#)).

Licensed Occupational Therapists

Occupational therapy services must be provided by a licensed occupational therapist or occupational therapy assistant serving under the direction of a licensed occupational therapist (see [WAC 296-23-230](#)).

Nonboard Certified/Qualified Physical Medicine Providers

Special payment policies apply for attending doctors who aren't board qualified or certified in physical medicine and rehabilitation:

- They **won't be paid** for CPT[®] codes 97001-97799.
- They may perform physical medicine modalities and procedures described in CPT[®] codes 97001-97750 if their scopes of practice and training permit it, but must bill local code 1044M for these services.
- Local code 1044M is limited to 6 units per claim, except when the attending provider practices in a remote location where no licensed physical therapist is available.
- After 6 units, the patient must be referred to a licensed, physical or occupational therapist or physiatrist for such treatment except when the attending provider practices in a remote location. Refer to [WAC 296-21-290](#) for more information.

1044M Physical medicine modality (ies) and/or procedure(s) by attending provider who isn't board qualified or certified in physical medicine and rehabilitation. Limited to 6 units except when provider practices in a remote area. \$ 43.06

Who Won't Be Paid For Physical Medicine Services

- Physical or occupational therapist students
- Physical or occupational therapist assistant students
- Physical or occupational therapist aides
- Athletic trainers

PHYSICAL AND OCCUPATIONAL THERAPY

Billing Codes

Physical and occupational therapists must use the appropriate CPT[®] and HCPCS codes 64550, 95831-95852, 95992, 97001-97799 and G0283, with the exceptions noted later in the Noncovered and Bundled Codes section. They must bill the appropriate **covered** HCPCS codes for miscellaneous materials and supplies. For information on surgical dressings dispensed for home use, refer to the [Supplies, Materials and Bundled Services](#) section, page **136**. If more than 1 patient is treated at the same time use CPT[®] code 97150. Refer to the Physical Medicine [CPT[®] Codes Billing Guidance](#) section, page **70** for additional information.

Noncovered and Bundled Codes

The following physical medicine codes aren't covered:

CPT [®] Code
97005
97006
97033

The following are examples of bundled items or services:

- Application of hot or cold packs.
- Ice packs, ice caps and collars.
- Electrodes and gel.
- Activity supplies used in work hardening, such as leather and wood.
- Exercise balls.
- Therataping.
- Wound dressing materials used during an office visit and/or physical therapy treatment.

Refer to the appendices for complete lists of noncovered and bundled codes.

Untimed Services

Supervised modalities and therapeutic procedures that don't list a specific time increment in their description are limited to 1 unit per day:

CPT [®] Code	CPT [®] Code
97001	97018
97002	97022
97003	97024
97004	97026
97012	97028
97014	97150
97016	

Daily Maximum for Services

The daily maximum allowable fee for physical and occupational therapy services (see [WAC 296-23-220](#) and [WAC 296-23-230](#) \$ 118.07

The daily maximum applies to CPT® codes 64550, 95831-95852 and 97001-97799 and HCPCS code G0283 when performed for the same claim for the same date of service. If physical, occupational, and massage therapy services are provided on the same day, the daily maximum applies once for each provider type.

If the worker is treated for 2 separate claims with different allowed conditions on the same date, the daily maximum will apply for each claim.

If part of the visit is for a condition unrelated to an accepted claim and part is for the accepted condition, therapists must apportion their usual and customary charges equally between the insurer and the other payer based on the level of service provided during the visit. In this case, separate chart notes for the accepted condition should be sent to the insurer since the employer doesn't have the right to see information about an unrelated condition.

The daily maximum allowable fee doesn't apply to:

- Performance based physical capacities examinations (PCEs),
- Work hardening services,
- Work evaluations or
- Job modification/prejob accommodation consultation services.

PHYSICAL AND OCCUPATIONAL THERAPY EVALUATIONS

Use CPT® codes 97001 through 97004 to bill for physical and occupational therapy evaluations and reevaluations. Use CPT® codes 97001 and 97003 to report the evaluation by the physician or therapist to establish a plan of care. Use CPT® codes 97002 and 97004 to report the evaluation of a patient who has been under a plan of care established by the physician or therapist in order to revise the plan of care. CPT® codes 97002 and 97004 have no limit on how frequently they can be billed.

PHYSICAL CAPACITIES EVALUATION

The following local code is payable only to physicians who are board qualified or certified in physical medicine and rehabilitation, and physical and occupational therapists. The evaluation must be provided as a 1-on-1 service.

1045M Performance-based physical capacities evaluation with report and summary of capacities \$ 705.78
(Limit of 1 per 30 days)

POWERED TRACTION THERAPY

Powered traction devices **are covered** as a physical medicine modality.

The insurer **won't pay** any additional cost when powered devices are used. Published literature has not substantially shown that powered devices are more effective than other forms of traction, other conservative treatments or surgery. This policy applies to all FDA approved powered traction devices. For more information go to

<http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/Pwdtractiondevices.asp>

WOUND CARE

Debridement

Therapists must bill CPT® 97597, 97598 or 97602 when performing wound debridement that exceeds what is incidental to a therapy (for example, whirlpool).

Wound dressings and supplies used in the office are bundled and aren't separately payable.

Wound dressings and supplies sent home with the patient for self-care can be billed with HCPCS codes appended with local modifier –1S. See the [Supplies, Materials and Bundled Services](#) section, page 136 for more information.

Electrical Stimulation for Chronic Wounds

Electrical stimulation passes electric currents through a wound to accelerate wound healing. Electrical stimulation is **covered** for the following chronic wound indications:

- Stage III and IV pressure ulcers
- Arterial ulcers
- Diabetic ulcers
- Venous stasis ulcers

Prior authorization is required if electrical stimulation for chronic wounds is requested for use on an outpatient basis using the following criteria:

- Electrical stimulation will be authorized if the wound hasn't improved following 30 days of standard wound therapy.
- In addition to electrical stimulation, standard wound care must continue.
- In order to pay for electrical stimulation beyond 30 days, licensed medical personnel must document improved wound measurements within the past 30 days.

Use HCPCS code G0281 to bill for electrical stimulation for chronic wounds. For more information go to

<http://www.ini.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/ElecStimofChronicWounds.asp>

MASSAGE THERAPY

Massage is a **covered** physical medicine service when performed by a licensed massage therapist ([WAC 296-23-250](#)) or other covered provider whose scope of practice includes massage techniques.

Massage therapists must bill CPT® code 97124 for all forms of massage therapy, regardless of the technique used. The insurer **won't pay** massage therapists for additional codes.

Massage therapists must bill their usual and customary fee and designate the duration of the massage therapy treatment.

Massage therapy is paid at 75% of the maximum daily rate for physical and occupational therapy services and the daily maximum allowable amount is \$ 88.55

The following are bundled into the massage therapy service and aren't separately payable:

- Application of hot or cold packs,
- Anti-friction devices and
- Lubricants (For example, oils, lotions, emollients).

Refer to [WAC 296-23-250](#) for additional information.



Document the amount of time spent performing the treatment. Your documentation must support the units of service billed.

PHYSICAL MEDICINE CPT® CODES BILLING GUIDANCE

Timed Codes

Some physical medicine services (e.g. ultrasound and therapeutic exercises) are billed based on the number of minutes spent performing the service. These services are referred to as 'timed services' and are billed using 'timed codes'.

Timed codes can be identified in CPT® by the code description. The definition will include words such as 'each 15 minutes'.

Providers **must document** in the daily medical record (chart note and flow sheet, if used):

- the amount of time spent for each time based service performed
- the specific interventions or techniques performed, including:
- frequency and intensity (if appropriate), and
- intended purpose of each intervention or technique.

Simply documenting the procedure code and the amount of time the service is performed is insufficient and may result in denial of the bill or recoupment of payment. All documentation must be submitted to support your billing (e.g. flow sheets, chart notes, and reports.)



Documenting a range of time (e.g. 8-22 minutes) for a timed service isn't acceptable. Providers must document the actual amount of minutes spent performing the service.

The number of units you can bill is determined by the time spent performing each 'timed service', and is constrained by the total number of minutes spent performing these services on a given day. Add together the minutes spent performing each individual time based service to obtain the total minutes spent performing time based services, and use the table below to obtain the number of units that can be billed for these services.

Units Reported	Number Minutes
1 unit	≥ 8 minutes to < 23 minutes
2 units	≥ 23 minutes to < 38 minutes
3 units	≥ 38 minutes to < 53 minutes
4 units	≥ 53 minutes to < 68 minutes
5 units	≥ 68 minutes to < 83 minutes
6 units	≥ 83 minutes to < 98 minutes
7 units	≥ 98 minutes to < 113 minutes
8 units	≥ 113 minutes to < 128 minutes

NOTE: The above schedule of times doesn't imply that any minute until the 8th should be excluded from the total count. The timing of active treatment counted includes all direct treatment time.

For example, if you perform 10 minutes of CPT® 97110 (therapeutic exercises) and 12 minutes of CPT® 97140 (manual therapy), you have performed 22 minutes of 'timed code' services. This equates to 1 unit of service that can be billed. Since the most time was spent performing manual therapy, bill 1 unit of 97140.

Examples

The following charts are examples of how the required elements of interventions can be documented. These examples aren't reflective of a complete medical record for the patient's visit. The other elements of reporting (SOAP) must also be documented.

Example 1

Time	Procedural Intervention	Specific Intervention	Purpose
20'	Therapeutic Exercise	Left leg-Straight Leg Raises X 4 directions; 3 lbs. each direction. 10 reps x 2 sets	Strength and endurance training for lifting
15'	Neuromuscular Reeducation	One leg stance 45 seconds left, 110 seconds on right using balance board x 2 sets each	Normalize balance for reaching overhead
10'	Cold Pack	Applied to left knee	Decrease edema

Total timed intervention: 35 minutes

Total treatment time: 45 minutes

The total treatment time spent performing timed services is 35 minutes. A maximum of 2 units of timed services can be billed. **Correct billing of these services is:**

- 97110 (therapeutic exercise) X 1 unit; and
- 97112 (neuromuscular reeducation) X 1 unit

Example 2

Time	Procedural Intervention	Specific Intervention	Purpose
8'	Attended E-Stim and Ultrasound performed simultaneously	5mA right forearm 1.5 W/cm ² ; 100% right forearm	Increase joint mobility
8'	Whirlpool	Heat bath to right forearm and hand	Facilitate movement; reduce inflammation
10'	Therapeutic Exercise	Active assisted ROM to right wrist; flexion/extension; 15 reps x 2 sets	Increase motion and strength for gripping

Total timed intervention: 18 minutes

Total treatment time: 26 minutes

The total treatment time spent performing timed services is 18 minutes. A maximum of 1 unit of timed service can be billed. **Correct billing of these services is:**

- 97110 (therapeutic exercise) X 1 unit; and
- 97022 (whirlpool) X 1 unit

Prohibited Pairs

A therapist can't bill any of the following pairs of CPT[®] codes for outpatient therapy services provided simultaneously to 1 or more patients **for the same time period**.

- Any 2 CPT[®] codes for “therapeutic procedures” requiring direct, 1-on-1 patient contact.
- Any 2 CPT[®] codes for modalities requiring “constant attendance” and direct, 1-on-1 patient contact.
- Any 2 CPT[®] codes requiring either constant attendance or direct, 1-on-1 patient contact—as described above—. For example: any CPT[®] codes for a therapeutic procedure with any attended modality CPT[®] code.
- Any CPT[®] code for therapeutic procedures requiring direct, 1-on-1 patient contact with the group therapy CPT[®] code. For example: CPT[®] code 97150 with CPT[®] code 97112.
- Any CPT[®] code for modalities requiring constant attendance with the group therapy code. For example: (CPT[®] code 97150 with CPT[®] code 97035)
- Any untimed evaluation or reevaluation code with any other timed or untimed CPT[®] codes, including constant attendance modalities, therapeutic procedures and group therapy.

DETERMINING WHAT TIME COUNTS TOWARDS TIMED CODES

Providers report the code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services aren't to be counted in determining the treatment service time. In other words, the time counted as “intraservice care” begins when the therapist or physician (or a physical therapy or occupational therapy assistant under the supervision of a physician or therapist) is directly working with the patient to deliver treatment services. The patient should already be in the treatment area (For example, on the treatment table or mat or in the gym) and prepared to begin treatment. The time counted is the time the patient is treated. The time the patient spends not being treated because of the need for toileting or resting shouldn't be billed. In addition, the time spent waiting to use a piece of equipment or for other treatment to begin isn't considered treatment time.

Regardless of the number of units billed, the daily maximum fee for services won't be exceeded.

More information about L&I's Physical, Occupational and Massage Therapy policies is also available on L&I's web site at

<http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/Therapy/default.asp>

WORK CONDITIONING AND WORK HARDENING

Work Conditioning

Work Conditioning is an intensive, work-related, goal-oriented conditioning program designed specifically to restore function for work. These programs are reimbursed as outpatient occupational and physical therapy under the daily fee cap. See [WAC 296-23-220](#) and [WAC 296-23-230](#).

Guidelines:

- Frequency: at least 3 times per week and no more than 5 times per week
- Duration: No more than 8 weeks for 1 set. 1 set equals up to 20 visits.
- An additional 10 visits may be approved upon review of progress
- Plan of Care: Goals are related to:
 - increasing physical capacities;
 - return to work function; and
 - establishing a home program allowing the individual to progress and/or maintain function after discharge.
- Documentation: Includes return to work capacities which may include lifting, carrying, pushing, pulling, sitting, standing, and walking tolerances
- Treatment: May be provided by a single therapy discipline (PT or OT) or combination of both (PT and OT).
 - Physical and occupational therapy visits accumulate separately and both are allowed on the same date of service.
 - Billing reflects active treatment. Examples include CPT 97110, 97112, 97530, 97535, and 97537.

Work Hardening

Work hardening is an interdisciplinary, individualized, job specific program of activity with the goal of return to work. Work hardening programs use real or simulated work tasks and progressively graded conditioning exercises that are based on the individual's measured tolerances. Work hardening provides a transition between acute care and successful return to work and is designed to improve the biomechanical, neuromuscular, cardiovascular and psychosocial functioning of the worker. Work hardening programs require prior approval by the worker's attending physician and **prior authorization** by the claim manager.

Only L&I approved work hardening providers will be paid for work hardening services.

More information about L&I's work hardening program, including a list of approved work hardening providers, criteria for admission into a work hardening program and other work hardening program standards is available on L&I's web site at

<http://www.lni.wa.gov/ClaimsIns/Providers/TreatingPatients/RTW/WorkHard/default.asp>

This information is also available by calling the work hardening program reviewer at (360) 902-4480.

The work hardening evaluation is billed using local code 1001M. Treatment is billed using CPT® codes 97545 and 97546. These codes are subject to the following limits:

Work hardening programs are authorized for up to 4 weeks.

Code	Description	Unit limit (four week program)	Unit price
1001M	Work hardening evaluation	6 units (1 unit = 1 hour)	\$ 117.02
97545	Initial 2 hours per day	20 units per program; max. 1 unit per day per worker (1 unit = 2 hours)	\$ 133.37
97546	Each additional hour	70 units per program; add-on, won't be paid as a stand-alone procedure per worker per day. (1 unit = 1 hour)	\$ 62.53

Program extensions

Program extensions must be authorized in advance by the claim manager and are based on documentation of progress and the worker's ability to benefit from the program extension up to 2 additional weeks. Additional units available for extended programs

Code	Description	6 week program limit
1001M	Work hardening evaluation	no additional units
97545	Initial 2 hours per day	10 units (20 hours)
97546	Each additional hour	50 units (50 hours)

Providers may only bill for the time that services are provided in the presence of the client. The payment value of procedure codes 97545 and 97546 takes into consideration that some work occurs outside of the time the client is present (team conference, plan development, etc.).

Time spent in treatment conferences **isn't covered** as a separate procedure regardless of the presence of the patient at the conference. Job coaching and education are provided as part of the work hardening program. These services must be billed using procedure codes 97545 and 97546.

Billing for additional services

The provision of additional services during a work hardening program is atypical and must be authorized in advance by the claim manager. Documentation must support the billing of additional services.

Billing for less than 2 hours of service in 1 day (97545)

Services provided for less than 2 hours on any day don't meet the work hardening program standards. Therefore, the services must be billed outside of the work hardening program codes. For example, the worker arrives for work hardening but is unable to fully participate that day. Services should be billed using CPT® codes that appropriately reflect the services provided. This should be considered as an absence in determining worker compliance with the program. The standard for participation continues to be a minimum of 4 hours per day, increasing each week to 7-8 hours per day by week 4.

Billing less than 1 hour of 97546

After the first 2 hours of service on any day, if less than 38 minutes of service are provided the -52 modifier must be billed. For that increment of time, procedure code 97546 must be billed as a separate line item with a -52 modifier and the charged amount prorated to reflect the reduced level of service. For example: Worker completes 4 hours and 20 minutes of treatment. Billing for that date of service would include 3 lines:

Code	Modifier	Charged Amt	Units
97545		Usual and customary	1
97546		Usual and customary	2
97546	-52	33% of usual and customary (completed 20 of 60 minutes)	1

Billing for services in multidisciplinary programs

Each provider must bill for the services that they are responsible for each day. Both occupational and physical therapists may bill for the same date of service.

Only 1 unit of 97545 (first 2 hours) will be paid per day per worker and the total number of hours billed shouldn't exceed the number of hours of direct services provided.

Example: The occupational therapist (OT) is responsible for the work simulation portion of the worker's program, which lasted 4 hours. On the same day, the worker performed 2 hours of conditioning/aerobic activity that the physical therapist (PT) is responsible for. The 6 hours of services could be billed in 1 of 2 ways.

Option 1		
PT	1 unit 97545	2 hours
OT	4 units 97546	4 hours
	Total hours billed	6 hours

Option 2		
OT	1 unit 97545 +	2 hours
	2 units 97546	2 additional hours
PT	2 units 97546	2 hours
	Total hours billed	6 hours

Billing for evaluation and treatment on the same day – multiple disciplines

If both the OT and the PT need to bill for 1 hour of evaluation and 1 hour of treatment on the same date of service, the services must be billed as follows:

Provider	Service	Bill As:
OT	1 hour evaluation	1 unit 1001M
PT	1 hour evaluation	1 unit 1001M
OT (or PT)	1 hour treatment	1 unit 97545 with modifier -52 (billed amount proportionate to 1 hour)
PT (or OT)	1 hour treatment	1 unit 97546

OSTEOPATHIC MANIPULATIVE TREATMENT

Only osteopathic physicians may bill osteopathic manipulative treatment (OMT). CPT® code 97140 **isn't covered** for osteopathic physicians.

For OMT services body regions are defined as:

- Head
- Cervical
- Thoracic
- Lumbar
- Sacral
- Pelvic
- Rib cage
- Abdomen and viscera regions
- Lower and upper extremities

These codes ascend in value to accommodate the additional body regions involved. Therefore, only 1 code is payable per treatment. For example, if 3 body regions were manipulated, 1 unit of the correct CPT® code would be payable.

OMT includes pre- and post-service work (For example, cursory history and palpatory examination). E/M office visit service may be billed in conjunction with OMT **only when all of the following conditions are met:**

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post-service work included with OMT, and
- There is documentation in the patient's record supporting the level of E/M billed, and
- The E/M service is billed using the -25 modifier.

The insurer **won't pay** for E/M codes billed on the same day as OMT without the -25 modifier.

The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis isn't required for payment of E/M in addition to OMT services on the same day.

The insurer may reduce payments or process recoupments when E/M services aren't documented sufficiently to support the level of service billed. The CPT® book describes the key components that must be present for each level of service.

ELECTRICAL STIMULATORS

Electrical Stimulators Used in the Office Setting

Providers may bill professional services for application of stimulators with the CPT® physical medicine codes when it is within the provider's scope of practice. Attending providers who aren't board qualified or certified in physical medicine and rehabilitation must bill local code 1044M.

Devices and Supplies for Home Use or Surgical Implantation

See the Transcutaneous Electrical Nerve Stimulators (TENS) section for policies pertaining to TENS units and supplies. Coverage policies for other electrical stimulators and supplies are described as follows.

Electrical Stimulator Devices for Home Use or Surgical Implantation

HCPCS Code	Brief Description	Coverage Status
E0744	Neuromuscular stim for scoli	Not covered
E0745	Neuromuscular stim for shock	Covered for muscle denervation only. Prior authorization is required.
E0747	Elec Osteo stim not spine	Prior authorization is required.
E0748	Elec Osteogen stim spinal	Prior authorization is required
E0749	Elec Osteogen stim, implanted	Authorization subject to utilization review.
L8680	Implantable neurostimulator electrode	Not covered
E0755	Electronic salivary reflex s	Not covered
E0760	Osteogen ultrasound, stimltor	Covered for appendicular skeleton only (not the spine). Prior authorization is required.
E0761	Nontherm electromgntc device	Covered
E0762	Trans elec jt stim dev sys	Not covered
E0764	Functional neuromuscular stimulator	Prior authorization is required
E0765	Nerve stimulator for tx n&v	Not covered
E0769	Electric wound treatment dev	Not covered

Electrical Stimulator Supplies for Home Use

HCPCS Code	Brief Description	Coverage Status
A4365	Adhesive remover wipes	Payable for home use only Bundled for office use
A4455	Adhesive remover per ounce	
A4556	Electrodes, pair	
A4557	Lead wires, pair	
A4558	Conductive paste or gel	
A5120	Skin barrier wipes box per 50	
A6250	Skin seal protect moisturizer	
E0731	Conductive garment for TENS	Not covered
E0740	Incontinence treatment system	Not covered

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS)

Transcutaneous electrical nerve stimulation (TENS), interferential current therapy (IFC) and percutaneous neuromodulation therapy (PNT) devices for use outside of medically supervised facility settings **aren't covered** for State Fund, Self-Insured and Crime Victims claims. This includes home use, purchase or rental of durable medical equipment (DME) and supplies. Use of these therapies will continue to be covered during hospitalization and in supervised facility settings.

On October 30, 2009, the State Health Technology Clinical Committee (HTCC) met in an open public meeting to review the evidence for Electrical Nerve Stimulation (ENS), including TENS, IFC and PNT, as treatments for acute and chronic pain. Based on a review of the best available evidence of safety, efficacy and cost-effectiveness, the committee's determination is that ENS is noncovered for use outside of medically supervised facilities. Purchase or rental of TENS, IFC, and PNT equipment and supplies isn't covered. The determination was made final by the HTCC on November 20, 2009. Complete information on this HTCC determination is available at: <http://www.hta.hca.wa.gov>.